

AmerGen Energy Company, LLC
Oyster Creek
US Route 9 South
P.O. Box 388
Forked River, NJ 08731-0388

10 CFR 50.73(a)(2)(i)

May 23, 2002
2130-02-20139

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington DC 20555

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report 02-001:
Plant Operations Outside of Technical Specifications
Due To A Degraded System

Enclosed is Licensee Event Report LER 02-001. This event did not affect the health and safety of the public.

If any additional information or assistance is required, please contact Mr. John Rogers of my staff at 609.971.4893.

Very truly yours,



Ron J. DeGregorio
Vice President, Oyster Creek

RJD/JJR

cc: Administrator, Region I
NRC Project Manager
Senior Resident Inspector

IE22

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)

Oyster Creek Unit 1

DOCKET NUMBER (2)

05000 - 219

PAGE (3)

1 of 4

TITLE (4)

Plant Operations Outside of the Technical Specifications due to a Degraded System

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
03	26	02	02	-- 01	-- 00	05	23	02		05000
										05000

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)				
N	100	20.2201(b)	20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)	
		20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
John Rogers	609.971.4893

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
B	IL	EHTR	GE	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

At 7:00 AM on March 23, 2002, a sufficient volume of water had condensed in the Offgas Radiation Monitor sample chamber to cause the monitor to read unacceptably low. This resulted in the monitor being incapable of performing its intended function of isolating the Off Gas Line if Technical Specification release limits were exceeded.

The sample chamber heat trace had failed allowing moisture to accumulate in the sample chamber. The system engineer, in response to a maintenance request, developed a troubleshooting plan which included a procedure to remove moisture from the sample chamber. On April 9, 2002, at 5:49 PM, draining was commenced on the sample chamber. Upon the draining of the chamber, indications returned to normal. The system was declared operable at 7:25 PM.

The cause of the Technical Specification violation was a failed sample chamber heat trace. The heat trace was restored to an operable condition. The safety significance of this occurrence was minimal. Although the Air Ejector Offgas Radiation Detection System was inoperable, the Stack Radioactive Gaseous Effluent Monitoring System was in operation. No unexpected activity was noted. Weekly samples performed by the chemistry department of air ejector offgas did not show an increase in offgas activity.

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TEXT CONTINUATION

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Oyster Creek, Unit 1	05000	YEAR	SEQUENTIAL NUMBER	REV	2 of 4
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

DATE OF DISCOVERY

On April 25, 2002, a review of system performance determined the Technical Specification Limit for the Offgas Radiation Monitor Out of Service time had been exceeded on March 26, 2002.

IDENTIFICATION OF OCCURRENCE

At approximately 7:00 AM on March 26, 2002, a 72 hour Technical Specification out of service allowance expired but a reactor shutdown was not commenced. This occurrence is considered reportable under 10 CFR 50.73(a)(2)(i).

CONDITIONS PRIOR TO DISCOVERY

The plant was operating at 100% power with all temperatures and pressures normal for full power operation.

DESCRIPTION OF OCCURRENCE

Before main condenser (EIIC - COND) air ejector offgas is discharged to the environment, a sample stream is passed through a six-foot section of four inch, internally polished, stainless steel pipe. Two ion chamber radiation detectors (EIIS - IL) monitor this sample chamber. At 7:00 AM on March 23, 2002, a sufficient volume of water had condensed in the Offgas Radiation Monitor sample chamber to cause the monitor to read unacceptably low. Although both detectors passed all Technical Specification required surveillances, the water resulted in the monitor being incapable of performing its intended function of isolating the offgas line if the Technical Specification release limits were exceeded. On April 7, 2002, the operators questioned the lower than normal Offgas Radiation Monitor readings and a Corrective Action Program document was issued. An inspection of the Air Ejector Offgas Sample Line for air leaks (which were thought to be the cause of the indications) was conducted. No air leaks were discovered. The downward trend continued and on April 9, 2002, at 1:28 PM, the Shift Manager declared the system inoperable, entered a 72 hour Technical Specification out of service allowance, and documented the abnormal radiation trend in a maintenance request.

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

DESCRIPTION OF OCCURRENCE (Cont.)

The system engineer, in response to the maintenance request, developed a troubleshooting plan which included a procedure to remove moisture from the sample chamber and initiated an Action Request to check the sample chamber heat trace (EIIC - EHTR). On April 9, 2002, at 5:49 PM, draining was commenced on the sample chamber. Indications returned to normal and the system was declared operable at 7:25 PM.

Subsequently, on April 25, 2002, an evaluation of monitor performance was completed and it was concluded that the monitor had become inoperable on March 23, 2002 at 7:00AM and continued in excess of the Technical Specification out of service allowance.

FAILURE DATA

General Electric; electrical heat trace.

APPARENT CAUSE

The failure of the sample chamber heat trace in the Air Ejector Off Gas sample system resulted in moisture collecting in the sample chamber. As water collected in the chamber, a decrease in offgas radiation indications occurred due to the displacement of the monitored gas away from the detectors.

A contributing cause was determined to be insufficient administrative controls to evaluate component degradation.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The safety significance of this occurrence was minimal. Although the Air Ejector Offgas Radiation Detectors were inoperable, the Stack Radioactive Gaseous Effluent Monitoring System was in operation. No unexpected activity was noted. Weekly samples performed by the chemistry department of air ejector offgas did not show an increase in offgas activity. Additionally the main steam line radiation detectors were in operation and did not indicate any fuel element failure. The plant remained within the Technical Specification Release Limits at all times. There was no unexpected radioactive release and thus there was no effect on the health and safety of the public.

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CORRECTIVE ACTIONS

Immediate Corrective Actions

Upon recognizing that the detection system was degraded, the sample chamber was drained and enhanced monitoring was commenced.

Short Term Corrective Actions

It was determined that the cause of the water buildup was a failure of the sample chamber heat trace.

New administrative controls have been initiated to evaluate detection system performance. If monitoring of these additional parameters indicates that the detection system performance has degraded, the sample chamber will be drained.

The heat trace was replaced and the radiation monitoring system restored to full operability on May 8, 2002.